STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155768	A. BUILDING	00	COMPLETED 02/15/2012
		133708	B. WING		02/15/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE VASHINGTON AVE	
EVANSV	ILLE PROTESTAN	IT HOME INC		SVILLE, IN 47714	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
1 0000					
, 	This visit was fo	or a Recertification and	F0000	Please accept this plan of correction	,
	State Licensure			as or credible allegation of	
	Survey Dates: February 8, 9, 10, 13, 14, 15, 2012			compliance, this plan of correction i	is
				submitted as part of regulatory	
				required response and should not b construed as agreement with the	
				deficiencies cited.	
	Facility Number	r: 001125			
	Provider Numbe	er: 155768			
	AIM Number: N	J/A			
	Survey Team:				
	Diane Hancock,	RN, TC			
	Vickie Ellis, RN	Ţ			
	Barbara Fowler,	RN			
	Amy Wininger,	RN			
	Company Do 1 To a				
	Census Bed Typ SNF= 39	e:			
		ified Comprehensive]=17			
	Residential=69	med Comprehensive]-1/			
	Total= 125				
	10141-123				
	Census Payor Ty	vne·			
	Medicare=13	JPC.			
	Other= 112				
	Total=125				
	120				
	Sample: 10				
	NCC Sample: 2				
	Supplemental Sa				
	Residential Sam	-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

001125

PRINTED: 03/01/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER:  155768	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMPI <b>02/15</b>	
	ROVIDER OR SUPPLIER  ILLE PROTESTANT HOME INC	3701 W	ADDRESS, CITY, STATE, ZIP CODE VASHINGTON AVE SVILLE, IN 47714	3	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
			CROSS-REFERENCED TO THE APPRODEFICIENCY)	DPRIATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM9C11

Facility ID: 001125

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155768	B. WIN			02/15/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ASHINGTON AVE		
EVANSV	ILLE PROTESTAN	T HOME INC			SVILLE, IN 47714		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<del> </del>	TAG	DEFICIENCY)		DATE
F0282	· · · · · · · · · · · · · · · · · · ·						
SS=D	facility must be provided by qualified persons in accordance with each resident's written						
	in accordance with plan of care.	n each resident's written					
	· '	ation interview and	F02	02	   F-282 Persons/Personal Care	. }	03/15/2012
		ation, interview and	1.02	02	Plan What corrective action v	_	03/13/2012
	•	e facility failed to ensure			be accomplished for the resident found to be affected		
	•	s followed for assisting					
		eating, for 1 of 3			by the deficient practice?		
	residents observe	ed for needing assistance			Resident #19 has been moved	l to	
	with eating, in th	e sample of 10.			an assist table for more direct		
	(Resident #19)				interaction with staff. Resident		
	, , , , , , , , , , , , , , , , , , ,				#19 had weight loss from Jan		
	Finding includes:				week 4 of weights to February week 1 of weights due to a		
					gastrointestinal virus. Residen	t l	
	Pagidant #10's al	inical record was			#19 weight had been identified		
					the week before survey and sh		
		12 at 10:32 a.m. The			was already receiving health		
	_	ses included, but were			shakes as a supplement for he		
	•	e following: depression,			weight loss and Remeron as a	n	
	failure to thrive,	atrial fibrillation,			appetite stimulant. Family and physician are aware of decrea		
	dementia, hypert	ension, and osteoporosis.			in weight. As of 2-28-12, the	36	
					resident no longer resides at the	ne	
	Resident #19's m	ost recent quarterly			facility. How other residents		
		Set [MDS] assessment,			potentially affected will be		
		ndicated the resident			identified and corrective		
	· ·	assistance of one person			actions taken? All residents		
	_	_			have the potential to be affected		
	_	resident had a care plan,			Under the direction of the DON		
		th an ongoing target date			care plans shall be audited for assist with eating. All		
	· ·	equiring extensive			residents identified to have an		
		ctivities of daily living,			assist with eating care plan ha		
	including eating.	Interventions included,			had their food consumption		
	but were not limit	ited to, the following:			record reviewed to ensure pro		
	"-Assess residen	ts mental status q [every]			intake. What measures shall	be	
		need for assistance			put in place or systemic		
		umption of meals and			changes made to ensure the		
	_	-			deficient practice does not		
	record consumpt	ion"			recur? To enhance currently		

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Event ID: TM9C11

Facility ID: 001125

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155768	B. WIN			02/15/	2012
		l .		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .		3701 W	ASHINGTON AVE		
EVANSV	ILLE PROTESTAN	T HOME INC		EVANS	VILLE, IN 47714		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
IAU	The resident had 8/19/11, with an 2/19/12, for a his The intervention limited to, the for "-Stay with her concurage to eat -Evaluate for research - Monitor and recearch - Offer substitute - staff assist with The resident's management of the staff assist with The resident with I loss over past 90 BMI [basal metalis seen monthly team] meetings. 6 months. She reshakes and receif used for appetite appetite. 2 call was [cubic centimeted day] last week  Review of the Management	a care plan, dated ongoing target date of story of failure to thrive. Is included, but were not similar and 100% of meals served It to		IAU	complaint operations, under the direction of the DON, nursing staff shall receive in servicing regarding care plan intervention which shall include but is not limited to assisting with eating. The DON or designee shall marounds in the dining rooms to ensure residents identified to need assist with eating are receiving assistance. How corrective actions will be monitored to ensure the deficient practice will not recur? Effective 3-12-12, a Quality Assurance program was implemented to ensure continumonitoring of identified residents who need assist with eating is implemented. All aud will be completed daily for 4 weeks, 5 times a week for 3 weeks, and 3 times a week for 3 weeks, and 3 times a week for weeks and then weekly thereafter. Any variation in regulatory guidelines will be corrected immediately. All aud will be submitted to the Quality Assurance Committee for reviand/or further corrective action Audits will not titrate down unlithe QA committee deems 100 compliance was achieved.	ee ons	DATE
	2/9/12 lunch, 0 [ 2/9/12 supper, 0	-					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM9C11

Facility ID: 001125

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155768		A. BUILI	DING	NSTRUCTION 00	(X3) DATE ( COMPL <b>02/15</b> /	ETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE		
EVANSV	ILLE PROTESTAN	THOME INC			ASHINGTON AVE VILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	2/10/12 breakfas 2/10/12 lunch, 25 2/10/12 supper, I 2/11/12 breakfas 2/11/12 lunch, 25 2/11/12 supper, I 2/12/12 breakfas 2/12/12 lunch, 0 2/12/12 supper, 0 2/13/12 breakfas 2/13/12 lunch, R 2/13/12 supper, 0 2/13/12 supper, 0 2/13/12 supper, 0 The resident's rec the following: Ja 2 100, week 3 98 week 1 91.4, wee was treated for a from 2/6 through On 2/13/12 at 5:0 was observed du She sat at the tab residents. She m herself. No one to assist the resid On 2/14/12 at 12 observed to delive tray to her. Her to opened, supplem and silverware se observed to sit in	t, 25 percent 5 percent R [refused] t, R [refused] 5 percent R [refused] t, R [refused] t, R [refused] [zero] 0 [zero] t, R [refused] [refused] 0 [zero] corded weights included anuary week 1 99.6, week 1.4, week 4 97, February 2 2 94. The resident urinary tract infection 1.2/13/12. 00 p.m., Resident #19 ring the evening meal. le with three other ade no effort to feed was observed to attempt					

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Event ID: TM9C11

Facility ID: 001125

If continuation sheet

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PRINTED: 03/01/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155768	A. BUILDING B. WING	00 	COMPLET 02/15/20	TED
	PROVIDER OR SUPPLIER  ILLE PROTESTANT HOME INC	3701 W	ADDRESS, CITY, STATE, ZIP CODE VASHINGTON AVE SVILLE, IN 47714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE (	(X5) COMPLETION DATE
	feed herself until 12:35 p.m. No staff members were observed to interact with the resident during that time. At that time, her table mate was observed talking to her and encouraging her to eat. The resident was observed to pick up a fork at that time and feed herself two bites of food. She was observed to take a couple sips of lemonade.  The observations were reviewed with the Administrator and Director of Nursing on 2/14/12 at 3:20 p.m. During interview at that time, they indicated they weren't sure the resident would allow anyone to feed her, but indicated someone should have attempted, or at least encouraged the resident to eat.  3.1-35(g)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM9C11

Facility ID: 001125

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	*	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155768	B. WIN			02/15/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ASHINGTON AVE		
F\/ΔNS\/	ILLE PROTESTANT	THOME INC			SVILLE, IN 47714		
					, IN 477 14		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	`	X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	LETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DA	.TE
F0312		unable to carry out					
SS=D	activities of daily linecessary services	~					
		g, and personal and oral					
	hygiene.	,, and percental and era					
	i	ation, interview and	F03	12	F-312 ADL Care Provided for	03/1:	5/2012
	record review, th	e facility failed to ensure			<u>Dependent Residents</u> What		
	· · · · · · · · · · · · · · · · · · ·	observed for needing			corrective action will be		
		ating, in the sample of			accomplished for the residen	t	
		assistance. (Resident			found to be affected by the	40	
		assistance. (Resident			deficient practice? Resident # has been moved to an assist	-19	
	#19)				table for more direct interaction	,	
					with staff. Resident #19 had	·	
	Finding includes	•			weight loss from Jan week 4 o	f	
					weights to February week 1 of		
	Resident #19's cl	inical record was			weights due to a gastrointestin		
	reviewed on 2/9/	12 at 10:32 a.m. The			virus. Resident #19 weight had		
	resident's diagno	ses included, but were			been identified the week before	₹	
		e following: depression,			survey and she was already receiving health shakes as a		
	failure to thrive,	• •			supplement for her weight loss		
	-	ension, and osteoporosis.			and Remeron as an appetite		
	dementia, nypero	ension, and osteoporosis.			stimulant. Family and physicial	n	
	5 11				were also already aware of		
		ost recent quarterly			decrease in weight. How other		
		Set [MDS] assessment,			residents potentially affected		
		ndicated the resident			will be identified and correcti	ve	
	required limited a	assistance of one person			actions taken? All residents		
	for eating. The r	esident had a care plan,			have the potential to be affected Under the direction of the DON		
		th an ongoing target date			care plans shall be audited for		
		quiring extensive			assist with eating. All		
	· ·	ctivities of daily living,			residents identified to have an		
					assist with eating care plan ha	ve	
		Interventions included,			had their food consumption		
		ted to, the following:			record reviewed to ensure pro		
		s mental status q [every]			intake. What measures shall I	oe	
		need for assistance			put in place or systemic		
	-Encourage cons	umption of meals and			changes made to ensure the deficient practice does not		
	record consumpti	ion"			recur? To enhance currently		

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Event ID: TM9C11

Facility ID: 001125

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPLETED	
		155768	A. BUII			02/15/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
E) (A N (O) (		T. I. O. I. E. I. I. O.			ASHINGTON AVE		
EVANSV	ILLE PROTESTAN	I HOME INC		EVANS	VILLE, IN 47714		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COM	PLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		ATE
IAG	The resident had 8/19/11, with an 2/19/12, for a his The intervention limited to, the for "-Stay with her dencourage to eat -Evaluate for rese. Monitor and rece-Offer substitute -staff assist with The resident's management of the staff assist with The resident [with] loss over past 90 BMI [basal metallis seen monthly it team] meetings. 6 months. She reshakes and receivated for appetite appetite. 2 call we [cubic centimeted day] last week Review of the M for February, 20 limited to, the for 2/9/12 breakfast,	a care plan, dated ongoing target date of story of failure to thrive. Is included, but were not story of meals to the story of meals served It to		IAG	complaint operations, under the direction of the DON, nursing staff shall receive in servicing regarding care plan intervention which shall include but is not limited to assisting with eating. The DON or designee shall may rounds in the dining rooms to ensure residents identified to need assist with eating are receiving assistance. How corrective actions will be monitored to ensure the deficient practice will not recur? Effective 3-12-12, a Quality Assurance program was implemented to ensure continumonitoring of identified resider who need assist with eating is implemented. All audits will be completed daily for 4 weeks, 5 times a week for 3 weeks, and then weekly thereafter. Any variation in regulatory guidelin will be corrected immediately, audits will be submitted to the Quality Assurance Committee review and/or further corrective action. Audits will not titrate do unless the QA committee deer 100% compliance was achieved.	e ns ake as ued ats 3 as All for e wn ns	AIE
	· ·	25 percent zero]					

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Event ID: TM9C11

Facility ID: 001125

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155768	B. WIN			02/15/	/2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
EVANSV	ILLE PROTESTAN	IT HOME INC			'ASHINGTON AVE VILLE, IN 47714		
			1	<u> </u>	VILLE, IIV 777 17		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1	2/10/12 breakfa	st, 25 percent					
	2/10/12 lunch, 2	• •					
	2/10/12 supper,	•					
	2/11/12 breakfa	st, R [refused]					
	2/11/12 lunch, 2	25 percent					
	2/11/12 supper,	R [refused]					
	2/12/12 breakfa	st, R [refused]					
	2/12/12 lunch, (	[zero]					
	2/12/12 supper,	0 [zero]					
	2/13/12 breakfa	st, R [refused]					
	2/13/12 lunch, I	R [refused]					
	2/13/12 supper,	0 [zero]					
		ecorded weights included					
	_	January week 1 99.6, week					
	· ·	8.4, week 4 97, February					
		eek 2 94. The resident					
		a urinary tract infection					
	from 2/6 throug	h 2/13/12.					
	On 2/13/12 at 5	:00 p.m., Resident #19					
		uring the evening meal.					
		ble with three other					
		nade no effort to feed					
		was observed to attempt					
	to assist the resi	•					
	On 2/14/12 at 1	2:00 noon, LPN #1 was					
	observed to deli	iver Resident #19's meal					
	tray to her. Her	meat was cut up, drinks					
	opened, suppler	ment poured into a cup,					
	and silverware	set up. The resident was					
	observed to sit i	n her wheelchair, with her					
	head in her hand	d and make no effort to					

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Facility ID: 001125

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CO	00	(X3) DATE COMPL	ETED
		155768	B. WING			02/15/	2012
	PROVIDER OR SUPPLIE			3701 W	.DDRESS, CITY, STATE, ZIP CODE ASHINGTON AVE VILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	members were of the resident duritime, her table in to her and encouresident was obsthat time and fee food. She was osips of lemonado. The observation Administrator at 2/14/12 at 3:20 pthat time, they in the resident would her, but indicate	bserved to interact with ng that time. At that nate was observed talking traging her to eat. The erved to pick up a fork at ed herself two bites of observed to take a couple etc.  s were reviewed with the nd Director of Nursing on o.m. During interview at adicated they weren't sure ld allow anyone to feed d someone should have least encouraged the					

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Event ID: TM9C11

Facility ID: 001125

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155768	B. WING		02/15/2012
NAME OF I	PROVIDER OR SUPPLIE	3	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				VASHINGTON AVE	
EVANSV	ILLE PROTESTAN	T HOME INC	EVANS	SVILLE, IN 47714	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	<b>}</b>	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0368 SS=D	provides at least t	eives and the facility three meals daily, at regular			
	times comparable community.	to normal mealtimes in the			
		11			
		more than 14 hours Intial evening meal and			
		owing day, except as			
	provided below.	ming ady, except de			
	1	offer snacks at bedtime			
	daily.				
		g snack is provided at			
		hours may elapse between			
		ning meal and breakfast the resident group agrees to			
		nd a nourishing snack is			
	served.	3			
	Based on observ	ration, interview, and	F0368	F-368 Frequency of	03/15/2012
	record review, tl	ne facility failed to ensure		meals/snacks at Bedtime Wh	nat
	· ·	North Nursing Unit was		corrective action will be	
		e snack, in that 1 of 3		accomplished for the resider	1t
		d oriented residents		found to be affected by the deficient practice? Resident:	#60
	*	he sample of 10,		was a resident council intervie	
		ne snacks were not		with surveyors. The facility is	
	offered. (Reside			unable to identify resident	
	officied. (Reside	mt 1100)		#60. How other residents	
	Finding includes			potentially affected will be identified and corrective	
	i manig merades	).		actions taken? All residents	
	During the grow	p meeting on 02/09/12 at		have the potential to be affect	ed.
				Under the direction of the DO!	N,
		one (1) resident in		food consumption records sha	ıll
	,	ident 60) was identified at		be audited for bedtime snack documentation. There are no	
		Activity Director to be		residents who had an incompl	ete
		Ouring interview at that		bedtime snack record and a	
	· ·	at indicated bedtime		weight loss.What measures	
	snacks were not	offered.		shall be put in place or	
				systemic changes made to	

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Facility ID: 001125

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.a	00	COMPL	ETED
		155768	A. BUII			02/15/	2012
		1 11	B. WIN				
NAME OF I	PROVIDER OR SUPPLIE	ER .		l	ADDRESS, CITY, STATE, ZIP CODE		
					ASHINGTON AVE		
EVANSV	ILLE PROTESTAN	NT HOME INC		EVANS	VILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The food consu	mption records of the			ensure the deficient practice		
	resident were re	eviewed on 02/14/12 at			does not recur? To enhance		
		e consumption record did			currently complaint operations		
		_			under the direction of the DON	١,	
	1	documentation an			nursing staff shall receive in		
	evening snack h	nad been offered or			servicing regarding bedtime		
	consumed.				snack documentation, bedtime	9	
					snack location, and timing of		
	During on inter	view with CNA #1 on			snack offering. All residents sh		
	_				have the 2 nd shift nurse revie		
		30 A.M. she indicated			the food consumption record f	or	
	each resident w	as offered juice from the			complete documentation of		
	hydration cart, a	and she had their			snacks offered. Fluids offered		
		morized. She further			shall be documented in cc and	1	
	-	d not offer a food snack			food in %. Refusals shall be	20	
					marked with an R. Any variation shall result in immediate	ווכ	
	but, if they aske	ed for a snack, she would			communication to the nursing		
	get it for them.				staff for correction. <b>How</b>		
					corrective actions will be		
	During an inter	view with the DoN			monitored to ensure the		
	_				deficient practice will not		
	_	rsing] on 02/14/12 at 3:15			recur? Effective 3-12-12, a		
	· ·	ated there was no			Quality Assurance program wa	30	
	documentation	food snacks were offered			implemented to ensure continu		
	in the evening.				monitoring of the bed time sna		
					is completed. The DON or	ioit	
	2 1 21(a)				designee will audit the bedtime	Α.	
	3.1-21(e)				snack record daily. All audits v		
					be completed daily for 4 week		
					times a week for 3 weeks, and		
					times a week for 3 weeks and		
					then weekly thereafter. Any		
					variation in regulatory guidelin	es	
					will be corrected immediately.	All	
					audits will be submitted to the		
					Quality Assurance Committee	for	
					review and/or further correctiv	е	
					action. Audits will not titrate do		
					unless the QA committee deel	ms	
					100% compliance was achieve	ed.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM9C11

Facility ID: 001125

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DUILDING	00	COMPLETED	
155768		A. BUILDING		02/15/2012	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	R			
EVANSVILLE PROTESTANT HOME INC				VASHINGTON AVE	
EVANSV	TILLE PROTESTAN	IT HOME INC	EVANS	SVILLE, IN 47714	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F9999					
	STATE FINDIN	IGS	F9999	F-9999 What corrective actio	n 03/15/2012
				will be accomplished for the	
	(a) The facility r	nust offer snacks at		resident found to be affected	
		ilust offer shacks at		by the deficient practice?	
	bedtime daily.			Resident #57, 58, 59, 61 and a	
				were resident council interview	V
	This State Rule	was not met as evidenced		with surveyors. The facility is	
	by:			unable to identify resident #57	
				58, 59, 61 and #62. <b>How other</b>	<b>I</b>
	Pagad on observation interview and			residents potentially affected	<b>I</b>
	Based on observation, interview, and			will be identified and correct	ive
	record review, the facility failed to ensure			actions taken? All residents	a d
	residents on the North Nursing Unit were			have the potential to be affected under the direction of the DON	
	offered a bedtime snack in that, 5 of 5			food consumption records sha	<b>I</b>
	supplemental sar	mple alert and oriented		be audited for bedtime snack	
	residents indicat	ted they were not offered		documentation. There are no	
		in a supplemental		residents who had an	
		* *		incomplete bedtime snack rec	ord
	• `	esidents #57, #58, #59,		and a weight loss. What	
	#61, #62)			measures shall be put in place	ce
				or systemic changes made to	<b>o</b>
	Finding includes	s:		ensure the deficient practice	
				does not recur? To enhance	
	During the grou	ip meeting on 02/09/12 at		currently complaint operations	
		five (5) residents in		under the direction of the DON	١,
				nursing staff shall receive in	
		idents 57, 58, 59, 61, 62)		servicing regarding bedtime snack documentation, bedtime	
		at that time, by the		snack location, and timing of	7
	Activity Directo	or to be interviewable.		snack offering. All residents sh	nall
	During the inter	rview at that time, all five		have the 2 nd shift nurse revie	
	residents indicat	ed they were not offered a		the food consumption record f	
	bedtime snack.	-		complete documentation of	
	Southing Shack.			snacks offered. Fluids offered	
	T21 C 1			shall be documented in cc and	i
		mption records of the		food in %. Refusals shall be	
		eviewed on 02/14/12 at		marked with an R. Any variation	on
	10:35 A.M The	e consumption records		shall result in immediate	
	I		1	communication to the nursing	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155768		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/15/2012				
	NAME OF PROVIDER OR SUPPLIER  EVANSVILLE PROTESTANT HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE  3701 WASHINGTON AVE  EVANSVILLE, IN 47714				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	evening snack had consumed.  During an intervolution of 2/14/12 at 10:3 each resident was hydration cart, a preferences menindicated she did but, if they asked get it for them.  During an intervolution of Nur P.M., she indicated she did but, if they asked get it for them.	norized. She further I not offer a food snack I for a snack, she would iew with the DoN sing] on 02/14/12 at 3:15		staff for correction. How corrective actions will be monitored to ensure the deficient practice will not recur? Effective 3-12-12, a Quality Assurance program wimplemented to ensure continuonitoring of the bedtime snadocumentation is completed. DON or designee will audit the bedtime snack record daily. A audits will be completed daily 4 weeks, 5 times a week for weeks, and 3 times a week for weeks and then weekly thereafter. Any variation in regulatory guidelines will be corrected immediately. All auwill be submitted to the Quality Assurance Committee for revand/or further corrective action Audits will not titrate down unthe QA committee deems 100 compliance was achieved.	dits  y iew n. less			

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Event ID: TM9C11

Facility ID: 001125

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155768		(X2) MULTIPLE CO  A. BUILDING  B. WING		ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/15/2012			
NAME OF PROVIDER OR SUPPLIER  EVANSVILLE PROTESTANT HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE  3701 WASHINGTON AVE  EVANSVILLE, IN 47714				
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE	
R0000	The following Residential Findings were cited in accordance with 410 IAC 16.2-5.  Quality review completed 2/16/12 Cathy Emswiller RN		R00	R0000 Please accept this plan of correct as or credible allegation of compliance, this plan of correction submitted as part of regulatory required response and should not construed as agreement with the deficiencies cited.		s		

State Form Event ID: TM9C11 Facility ID: 001125 If continuation sheet Page 15 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBER:	a. building 00		00	COMPLETED	
155768		B. WING			02/15/2012		
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/ASHINGTON AVE		
EVANSVILLE PROTESTANT HOME INC					SVILLE, IN 47714		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.  Based on observation and interview, the facility failed to ensure food was served under sanitary conditions, in that a window was opened to the outside with a ripped screen in place, a ceiling tile was out of place exposing insulation, the ventilation hood over the food preparation area had peeling paint, the top of the water pipes above the steam table were dirty, and the dishwashing area had mold on the backslash, for 1 of 1 observation of the North kitchen. This had the potential to affect 33 of 33 residents who resided in the North residential units and have meals served from the North kitchen.  Findings include:  During the observation of the North kitchen of 02/13/12 at 1:00 P.M., the		ID PREFIX		CROSS-REFERENCED TO THE APPROPRIATE		
	following was ob	oserved:			identified in the survey. Work order in-servicing shall be		
	a. An outside wi	indow was noted to be			completed for dietary department	ent	
	open with a torn	screen in place. During			to ensure staff education of the		
	_	nat time, the CDM			work order process and the		
		y Manager] indicated the			importance of communication	to	
	screen needed to				the environmental services		
		p-w••-			department. The safety committee shall meet monthly	to	
	h The ceiling til	le over the steam table			review sanitation inspections	io	
	_				performed by the registered		
		be pushed to the side			dietician or designee and work		
	exposing the insu	alation. During an			order completion of identified		

State Form Event ID: TM9C11 Facility ID: 001125 If continuation sheet Page 16 of 17

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	COMPLETE		
		155768	A. BUILDING B. WING		02/15/201	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	1	
EVANSVILLE PROTESTANT HOME INC				VASHINGTON AVE SVILLE, IN 47714		
EVANSV (X4) ID PREFIX TAG	summary s (EACH DEFICIEN REGULATORY OR interview at that she did not know open, but it shou  c. The ventilation prep area was obtained as of peeling in the state During an interview of the steam table was with a dark dustain interview at the indicated the subtained of the state of the steam table was observed to black mold-like should black m	time, the CDM indicated why the ceiling was ldn't be.  In hood over the food served to have multiple paint. iew at that time, the he peeling paint needed of.  It water pipe over the observed to be coated like substance. During nat time, the CDM estance appeared to be needed to be cleaned.  In of the dishwashing area be discolored with a substance at the caulk interview at that time, the che black substance			tive  e 2-12,  n was nued  t  north week eek  dits ity view on. nless	(X5) DMPLETION DATE

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